TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Donald D Bacon MD

**Respondent Name**
Texas Mutual Insurance

**MFDR Tracking Number**
M4-17-0332-01

**Carrier's Austin Representative**
Box Number 54

**MFDR Date Received**
October 7, 2016

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Denied for HCPCS codes. They are now changed to J7999 and I attached the supporting documentation. Doctor should be paid at fee schedule allowable. Allowed $0.00, doctor owed $17.82 for code billed. Plus $60.00 pharmacy compounding fee per refill that should be included in the total allowable for the refill of covered compounded drugs."

**Amount in Dispute:** $17.82

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Texas Mutual believes no additional payment is due."

**Response Submitted by:** Texas Mutual Insurance

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 7, 2016 | J7999, KD | $17.82 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 193 – Original payment decision is being maintained upon review it was determined that this claim was processed properly
   - 877 – Bill previously processed. Refer to Rule 133.250 regarding request for reconsideration

**Issues**

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

**Findings**

1. The requestor is seeking $17.82 for a refill of an implantable infusion pump for date of service March 7, 2016. The insurance carrier denied disputed services with claim adjustment reason code 193 – "Original payment decision is being maintained upon review it was determined that this claim was processed properly."

   28 Texas Administrative Code §134.203(b) states in pertinent part,

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   >
   > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

   Review of the applicable Medicare payment policy found at www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=54100, finds the following:

   > *Coding Guidelines:*
   >
   > 1. *When billing for compounded drugs, report HCPCS code J7999 with the KD modifier on a single claim line.*
   > 2. *Place quantity = '1' on the line billed for J7999KD.*
   > 3. *Enter the name and total dose (in mg or mcg) of each drug of the refill in Box 19 of the CMS 1500 or the appropriate comment loop of electronic claims (see examples below).*
   > 4. *Covered compounded single or combination drugs should be billed on a single detail line with the exceptions noted below in the examples.*
   > 5. *The ICD-10-CM code used on each detailed line must represent the condition treated by the drug(s) billed on that detail line.*
   > 6. *Drug doses used in narrative description must be in mgs or mcgs only. Do not report µgs*

   Review of the submitted medical claim finds box 19 of the CMS 1500 is blank. Therefore, the Division finds the requirements of the applicable Medicare payment policy were not met. No payment recommended.

2. Because the requirements of Rule 134.203(b) were not met, the Division is unable to support the request for additional payment.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

| | | |
|---|---|---|
| | | November 10, 2016 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.